M I N U T E S

Health Information Technology and Transparency
Advisory Board and Ad Hoc Expert Meeting

Health Information Exchange Standing Committee
Georgia Tech Research Institute
250 14th Street, N.W., Atlanta, GA
Room 119B
March 21, 2007
10:10 a.m. – 2:15 p.m.

Member Attendance:

Jeffrey Broka	James Buehler	Robert W. Bush
Tod Citron	Greg Fields	R. Scott Leavell
Patricia Massey	Dr. William McClatchey	Glenn Pearson
Dr. Winston Price	Gayle Ransom	Russell Williams

Health Information Exchange (HIE) Committee Guests
Juan Alaniz, *Project Manager*, *Division of Health Care Policy* at Washington State Health Care Authority

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The Health Information Exchange (HIE) Standing Committee convened at 10:10 a.m. Dr. McClatchey welcomed and introduced Mr. Juan Alaniz. Mr. Alaniz outlined how Washington (WA) State initiated their Health Information Infrastructure Advisory Board (HIIAB).

During the outlined presentation, Mr. Alaniz remarked, healthcare is the largest sector of the nation's economy, complex, and costly, with a structure that makes it difficult to build in the means to improve quality. Legislators were very supportive in addressing these concerns, as well as, how to empower consumers if data was not available to make health decisions or access their patient healthcare information. WA identified the promotion and expediting the adoption of Electronic Medical Records (EMRs) as a public goal. WA Senate Bill 5064 was enacted creating the Health Information Infrastructure Advisory Board (HIIAB), to serve as a blueprint for WA to adopt healthcare strategies, promote interoperability, prevention, healthy lifestyles and informed choices.

In order for state agencies to better manage chronic care, it was requested that healthcare information be transparent in the healthcare system in both the private and public sectors. The result was a better utilization of Health Information Technology (HIT). HIIAB determined that an important strategy would be to promote standards and systems compatible with systems currently in use. The Board advised legislators, as well as, the

executive branch about the identified implementation obstacles, recommendations of policies and insured strategies complied with federal and state laws.

The Georgia Department of Community Health (DCH) posed the following questions to Mr. Alaniz:

1. How did the HIIAB determine their objectives?
    - The HIIAB requested stakeholders provide their perspectives regarding S.B. 5064. They created value statements and guiding principles to determine how the Board would operate. Ten to twelve objectives were defined.

2. How do state agencies interact with the Board?
    - The Board was mandated by legislation. The state provided the staff and assistants for the Board with no superior or inferior relationship. The state and the Board established joint responsibilities with reporting, deliverables, next phases and establishing relationships with the legislature. The state would not have complete authority over the project. The responsibility for managing the project in WA was put under the Healthcare Authority Policy Office.

3. What was the involvement of stakeholders?
    - Before the legislation was approved there were numerous nominations for Board members. Stakeholders and health provider associations were asked to participate and provide their perspectives to identify tasks.

4. How has the state kept the Board engaged?
    - After establishing the Board members, the next step was selecting Committee members. In total 54 individuals made up the Board and Committees. These individuals represent a diversity of health care interest groups.
    - The Board was responsible for decision making. The Board provides assignments to the Committee. The Committee members provide the Board with recommendations and information.
    - The Board and Committee conducted joint monthly meetings. During these meetings that Board and Committee developed a 15-month project plan/timeline, reviewing other states HIT plans and presentations, as well as, utilizing existing Electronic Medical Record (EMR) studies and surveys to begin their process.
    - The Board had a consensus approach by identifying guiding principles and values, assessment tools and developing subcommittees. Within the subcommittees, a Board member would serve as the Subcommittee Chair

and a Committee member would serve as the Subcommittee Co-Chair, to assure joint solutions.

- Consumers were the toughest stakeholders to engage with HIT. The existing trust issues made it clear, consumers definitely needed to be included. Regardless of the strength of the health information system, it is null and void without the trust and confidence of consumers.

5. What do you recommend other states do to start the HIT process in order to ensure success?
    - Mr. Alaniz notes much has to do with transparency, which is an open process, a willingness not to have preconceived ideas on how things will work and not work and being open to recommendations and feedback.
    - The most difficult area is assuring the Board and Committee work together and moves on agreeable agenda items. The success rate is also determined by the leadership of the Board.
    - The project should have a Project Management team, support from top management and the ability to take risks, requiring abundant transparency in addition to allowing room for learning and correction.
    - The private sector tells you the solution is the easy part but getting buy-in and agreements are complicated.
    - The key is to have strong stakeholder management. Policy makers and stakeholders require leverage to build on existing factors.
    - Ensuring the project is economical and practical, has a sensible road map, and is realistic in keeping the project simple without costing millions of dollars.
    - Recognizing the risks and challenges of the business case and the return on the investment, as well as, financing issues, how to self-sustain and ways to govern.

6. How the project was funded?
    - The project is funded by community partnerships, the legislative budget and the Board and Committee members' contributions of their time spent on the project.

7. Was there a development of a communication team to communicate positive aspects of initiatives to consumers?
    - A communication team was not developed.

8. What are the areas that could have been different for the project?
    - The following areas could have been different: the utilization of funding, the consumer and provider pre-engagement process. Proficiently utilizing

the Board, Committee and consultants along with providing more staff support. Providing knowledge and obtaining expertise in communications and web-content. Conducting more public hearings or town hall meetings and providing better documentation.

- A major error in was having consultants perform the project management and HIT efforts. Consultants were initially hired to provide guidance to the Board, advising what was occurring at the national level, the requirements to meet the standards at the national level, defining and identifying the existing trends and myth and providing recommendations about the Distributive Model.

9. What was the community feedback on the Health Information Infrastructure?
    - Interoperability can only occur if the content, community and connectivity are present.

The following were Defined IT Model Options:

- Dispersed Model
    i. This is an existing system but does not work. This model is suitable for starting, but over time will need a "next level".

- Central Repository Model
    i. This model resembles a health trust. The model is not steadfast; stakeholders disliked due to non-leverage with what already exists. Technically this was the most expedient and politically it was most feasible.

- Competitive Health Record Banking Model
    i. Stakeholders felt this model would work best.

During the question and answer session, Mr. Alaniz described the function of the Health Bank Model. The Health Bank model is an alternative approach that is emerging where independent, non-profit entities maintain health information. Each Health Bank can hold high-value data sets such as critical care reports, x-ray film, etc. Patients select the Health Bank where the health data would be stored. An Account Locator Service can identify each individual's Health Bank. If an individual misplaced or loses their Health Bank, the locator service would advise the bank that stores their health information. The patient can deny or authorize their healthcare provider deposit and access data. Patients can also make inquiries to the Health Bank about what type of data exists.

Mr. Alaniz clarified the difference of a Personal Health Record (PHR) verses an Electronic Health Record (EHR). A PHR is offered to several organizations and the information entered from the patient is not clinical data. Several providers have issues

with PHRs and require a firewall between the PHR and EHR due to liability issues. Health Banks require state of the art computer methods to secure the information and a mechanism to assure each health information bank adheres to consumer protections and portability of information. WA is currently working on developing the banking concept for HIE.

The Health Information Exchange Committee adjourned at 2:15 p.m.

THESE MINUTES ARE HEREBY APPROVED AND ADOPTED THE _____ DAY OF _____, 2007.

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Robert Bush, Committee Chairperson R. Scott Leavell, Committee Secretary